Contract to Provide Health Management Services
Supplementary Agreement
Between
The Department of Human Services, Medical Services Division (North Dakota Medicaid)
and

_____
Disease Management Organization (Please Print or Type)

_____
North Dakota Medicaid ID Number

This agreement is entered into between the ND Department of Human Services, Medical Services Division (NDDHS), hereinafter referred to as "the Department", and the above name Disease Management Organization, hereinafter referred to as a "DMO", whose address/location is:

(Address) _____

(City) _____ (State) _____ (Zip Code) _____

(Phone) _____ (Medicaid Provider ID Number) _____

State Coverage Area _____

_____

Section I. General Statement of Purpose and Legal Authority

The Department contracts with DMO, which participates in the North Dakota Medicaid Program to provide Health Management services to certain Medicaid recipients with the following chronic conditions: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Health Failure (CHF). This agreement describes the terms and conditions under which the agreement is made and the responsibilities of the parties thereto.

This agreement shall be construed as supplementary to the usual provider agreement entered into by providers participating in the Medicaid Program, and all provisions of that agreement shall remain in full force and effect, except to the extent superseded by the specific terms of this agreement. The provider agrees to abide by all existing laws, regulations, rules, and procedures applicable to the North Dakota Health Management program and North Dakota Medicaid participation.

Section II. Definitions

Chronic Condition is a condition in which has lasted at least six months; can reasonably be expected to continue at least six months; or is likely to recur.

Cold-call marketing means any unsolicited personal contact by the DMO with a potential enrollee for the purpose of marketing as defined in this section.

Dual Eligibility means individuals who are entitled to Medicare Part A or Part B and are eligible for some form of Medicaid benefit.

Health Management eligible participant means being Medicaid eligible during the month HM benefits are delivered, having been diagnosed with Asthma, Diabetes, CHF or COPD, having one of the qualifying conditions meeting the definition of "chronic condition", and not possessing any exclusion during the month of HM services. Exclusions for participation in the program consist of: dual eligibility, recipient liability, additional major medical coverage (third party liability), residing in a nursing facility or intermediate care facility for the intellectually disabled (ICF/ID) and receiving health management services from another source (see reimbursement Section VII for further information on exclusions).

Participant means a Medicaid recipient, meeting the criteria of the Health Management (HM) program and providing written or verbal consent, documented in the participants care plan, to participate in the HM program.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Recipient means a person eligible for Medicaid benefits.

Section III. Scope of Service

DMO will provide health management services utilizing Department approved evidence based clinical guidelines from recognized sources. DMO has a process in place to review its clinical practice guidelines (at a minimum) every two years or when significant new findings become available. This includes a review of any participant and provider content, organizational training materials and curricula, web-based materials, verbal scripts, and any other materials relating to the program to ensure they are up to date and consistent with the current practice guidelines. As significant new findings become available in relation to the evidence based guidelines, DMO must review the findings and adopt them, as appropriate. Any changes to the guidelines must be submitted for approval by the Department.

DMO provides for a system of care coordination efforts which must include (at a minimum) the following Participant and Provider services and support:

Participant Services:

1. Assign nurse care managers to geographic areas within the State, allowing for cross-coverage as needed.

2. Document all levels of nurse care management services provided to each participant. The following elements of care coordination must be present in the recipient's care plan (take into consideration data types to which it has access to, such as claims, medical records, or participant self-reported information only): scheduled appointments, primary care provider, immunizations, referrals to specialty care and the result of the referral/appointment, test orders, test results, hospital inpatient admissions (to include reason), readmissions within 30 days, and discharges.

3. Coordinate, communicate, and integrate local service systems and supports by building collaborative relationships with local social and community, and state service agencies. Local state, and county services should be utilized if available.

4. Develop individualized care plans (to include identifying needs, implementation, and evaluation) in collaboration with the participant, family (if appropriate), and personal primary care provider.

5. Provide education and training to enhance the participant's understanding of the participant's condition(s) as well as the appropriate management of the participant's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the nurse care manager will work with the participant and their primary care provider to promote and coordinate the plan of care.

6. Provide participant with pre-visit preparations, reminders, and recall visits.

7. Contact and follow up with participants who have not kept appointments.

8. Provide written introductory information (in the form of a letter, brochure, or information packet). These must be supplied to the participant upon enrollment. Brochures/materials must be distributed to the Department, providers, and agencies as requested. The materials must include (at a minimum) the following:

    a. Description of the Health Management program.
    b. Explanation of the Health Management benefits to include information stating the program is voluntary and the participant may disenroll at any time.
    c. Description of how to access a nurse care manager.
    d. Describe the utilization and purpose of the Telephone Health Information Line, including hours of operation.
    e. Description of participant rights and responsibilities, including how to file a grievance or complaint, and information on the organizations confidentiality policy.

    All materials are subject to approval by the Department, including any revisions made to the materials.

9. Establish a systematic intake system which must include (at a minimum) the following data for each enrollee: name, Medicaid ID number, age, gender, racial or ethnic background, preferred language, literacy level or barriers to literacy level, vision and hearing needs, preferred method of communication, member contact information, primary care provider, dates of previous clinical visits, upcoming appointments, contact history log, self-management goal tracking, treatment plan and participant adherence to plan, comorbidities and other health conditions, health behaviors, psychosocial issues, schedule for follow-up contacts, and how the nurse care manager will use this information in actively involving the enrollee in their care.

10. Complete a Health Assessment Questionnaire/Tool (**subject to approval by the Department**) on all participants in order to identify risk factors, self-management skills, adherence to a treatment plan, knowledge of and adherence to a prescribed medication regimen, and intensity of care coordination efforts. This should incorporate all available clinical data collected from the eligible participants, providers, or health records to identify potential participants and stratify them for assignment to different levels of service intensity.

11. Establish a systematic screening process to identify eligible Medicaid participants who qualify for the Health Management program (DMO has a documented process for using the data types to which it has access such as claims, health records, participant self-reported information).

12. Obtain participant input which may be in the form of surveys, questionnaires, or focus groups.

13. Provide and make available advance preparations in the utilization of interpreter services for communication, care planning and education for each non-English-speaking participant. This may be accomplished by coordination through local county social service offices.

14. Continuous access to a designated clinic staff, or an on-call provider (toll-free), or toll-free health information line staffed by licensed nurses within the United States.
    The designated staff or phone system representative has continuous access to the health information provided by the participant, which may include the following:

    a. The participant's contact information, and primary care provider contact information.
    b. The participant's consent and restrictions for releasing medical information.
    c. The participant's preferred means of communication and primary language.
    d. The participant's diagnosis, medications, and care plan.

15. Establish adequate information, consents or authorizations, as well as privacy security measures required by HIPAA, Medicaid confidentiality, and any other federal and state laws.

Provider Services*:*

1. Provide the primary care provider with notification of health management services for their patient within 45 days after their patients have been engaged in the program. Engagement in the program constitutes live contact with participant, and signed written or documented verbal agreement to participate. The notification must include a description of the Health Management services, contact information, how the nurse care managers can assist and support the providers and treatment plan, how providers can communicate with the nurse care manager, how the nurse care managers provide information to the primary care providers about their patients, and how to file a grievance.

2. Collaborate with the participant's primary care provider (i.e., "medical home") and other medical professionals as needed.

3. Provide the primary care provider information about the condition and progress of the participant.

4. Identifying care opportunities that must be addressed through coordination efforts with the appropriate medical team.

5. Develop a grievance policy to handle any grievances or complaints by providers. This policy must address how DMO will handle grievances, time frame for responding, addressing the grievance, and reporting log.

6. Establish adequate information, consents, or authorizations; as well as privacy security measures required by HIPAA, Medicaid confidentiality, and any other federal and state laws.

DMO will implement a Quality Management and Improvement Program and Grievance Process. This will include the following:

1. Develop and implement Quality Management (QM) oversight that incorporates initiatives, strategies, staff time, and organization methodologies for ongoing quality assurance, quality improvement, and performance assessment activities.

2. Identify a qualified, key individual to be responsible for the operation and success of the quality management program.

3. Study and evaluate issues that the Department may periodically identify.

4. DMO must provide a written description of the QM program including program structure and processes. These structures and processes are subject to approval by the Department.

5. Develop a training plan for staff which includes documentation of completed training and attendance log. This is to be submitted to the Department on a semi-annual basis.

6. Develop a grievance policy to handle any grievances and/or complaints by participants and/or providers. This policy must address how DMO will handle grievances, time frame for responding, addressing the grievance and developing a reporting log. The log will include: date of grievance, who submitted the grievance (i.e. participant or provider), result/remedy of the grievance, time-frame for responding to the grievance, any quality management and improvement changes or activities which resulted from any grievance. The grievance policy is subject to approval by the State. The grievance log will be submitted to the State on a quarterly basis.

Section IV. Health Management Services (General Terms and Conditions)

1. Be a North Dakota Medicaid enrolled provider.

2 Comply with all applicable Federal and State laws and regulations.

3. Do not discriminate on the basis of health status or need for health care services.

4. Do not discriminate against individuals enrolled on the basis of race, color, gender, age, disability, or national origin. DMO will not use any policy or practice that has the effect of discriminating on the basis of race, color, gender, age, disability, or national origin.

5. DMO may disenroll or terminate the DMO-Participant relationship by providing 30 days written notice to the recipient and to the Department. Reason for the termination must be considered "good cause" as outlined in the M*anaged Care chapter* of the *General Information for Providers manual.* These reasons must be explained in writing, be non-discriminatory, and generally applied to DMO's entire participant base, and approved by the Department.

6. DMO agrees not to distribute any marketing materials without first obtaining approval from the Department.

7. DMO agrees not to, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

8. DMO agrees to provide potential participants with accurate oral and written information he or she needs to make an informed decision on whether to enroll.

9. DMO agrees not to seek to influence the recipient to not enroll in or to disenroll from another Health Management product.

Section V. Reports

Reports will be due 45 days after the end of a reporting period. Quarterly reports will reflect the following schedule: January 1-March 31, April 1-June 30, July 1-August 31, and October 1-December 31. Semi-annual reports will reflect January 1-June 30 and July 1-December 31. The

report for the last quarter of the contract period (i.e., October 1 – December 31) must be submitted by January 15 (after the end of the contract period).

Reports will be submitted electronically to the Department through secure file transfer protocol. Reporting activities are subject to change at the Department's discretion. Payment to DMO is contingent upon the Department's receipt of specified reports on schedule; late or insufficient reports will result in the Department withholding payment until adequate reports are received. Reporting requirements are subject to change at the Department's discretion.

See *Attachment A* for the required reports.
See *Attachment B* for the required format.

Section VI. Program Evaluation and Oversight

1. The Department may conduct on-site reviews and may request additional documentation prior to and during the operation of the Health Management program.

2. A program evaluation process will be completed by the Department's data analytic vendor. Program evaluation will begin immediately upon program implementation and continue through the length of the program. DMO will be required to collect and submit the program data necessary to meet the needs of the defined evaluation process and any other data requested by the Department.

3. DMO shall cooperate with the Department and its data analytic vendor in conducting external evaluations by providing requested data and information as needed.

4. DMO will be required to submit additional information to assist the Department with rate setting for the HM program. The type of information that will be needed may include time spent on case management activities and other related activities.

Section VII. Reimbursement

1. The parties agree that DMO shall be reimbursed as follows:

    a. DMO will be reimbursed per qualified Medicaid eligible member/per month as provided in the fee schedule.
    b. Recovery of health management fees is at the discretion of the Department.

2. Reimbursement will only be made for those enrollees:

    a. That are Medicaid eligible for the month receiving health management services.
    b. That do not possess any of the following exclusions during the month services are received:

        i. Dual Eligible;

ii. Recipient Liability;
iii. Other Major Medical Coverage (TPL);
iv. Resides in a nursing facility or intermediate care facility for the intellectually disabled (ICF/ID);
v. Enrolled with another Health Management Provider. Only one Medicaid enrolled Health Management provider/clinic/DMO will be reimbursed for a member per month. Duplicative payments for the same member will not be reimbursed within the same month. Payment will be made to the first billing provider of services for that participant.

c. That have signed a written agreement or provided verbal consent (which is documented in the participant's plan of care, registry system or medical record) to participate in the Health Management program.
d. That have been diagnosed by a licensed provider (within their scope of practice) as having one (or more) of the following four conditions:

i. Asthma
ii. Diabetes
iii. Chronic Obstructive Pulmonary Disease
iv. Congestive Heart Failure

e. That has a condition (Asthma, Diabetes, COPD, or CHF) that is chronic.

3. DMO must submit a claim, per eligible participant/per month by either submitting a paper CMS-1500 claim form or a HIPAA compliant 837 electronic claim transaction.

DMO will bill with the date of service spanning the entire month. Only one service per month can be billed for each individual participant.

HCPCS code S0280 will be billed for the Initial Care Coordination visit ONLY.

HCPCS code S0281 will be billed for each additional month of service.

Modifiers MUST be included with each HCPCS code and would be billed for each chronic condition as follows:

Modifier U4: Asthma
Modifier U5: CHF
Modifier U6: COPD
Modifier U7: Diabetes

Section VIII. Sanctions

Sanctions are listed per the *General Information for Providers-Medicaid and Other Medical Assistance Programs* Manual, Managed Care Chapter. Sanctions can be imposed pursuant to North Dakota Administrative Code Chapter 75-02-05.

Section IX. HIPAA

DMO must establish adequate consents/authorizations, information, and privacy security measures to comply with HIPAA requirements and other federal and state laws.

Section X. Fraud and Abuse

DMO must report any possible instances of Medicaid fraud to the Department immediately upon receipt of information.

Section XI. Termination from Participation

1. This agreement may be terminated by either party by providing written notice 30 days in advance of the desired date of termination or removal. The 30 days will allow participants time to select another Health Management provider.

2. The Department may terminate the agreement immediately upon written notice to DMO when such termination is considered to be in Medicaid's best interest to assure the continuation of necessary and appropriate service to Medicaid recipients.

Signature of DMO Representative	Title	Date

Signature of Medical Services Representative	Title	Date